ROCKAWAY TOWNSHIP PUBLIC SCHOOLS

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name:_____ **Date of plan:** _____

Date of birth:_____/____/_____ **Age**_____ **Weight:**_____kg

Attach child's photo

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - ☐ Ask for ambulance with epinephrine.
   - ☐ Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - ☐ Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - ☐ Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - ☐ Antihistamine
   - ☐ Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):_____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose):_____ (*Use 0.15 mg, if 0.10 mg is not available)
Other (for example, inhaler/bronchodilator if child has asthma):_____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

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Child's name: _____ **Date of plan:** _____

Additional Instructions: **Please sign**

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

ROCKAWAY TOWNSHIP PUBLIC SCHOOLS

Delegation Form

The delegate serves as a critical member of a team management approach whose goal is to provide the best care for students while at school and school-sponsored functions. Although not typically a health care professional, the delegate voluntarily is trained and is expected to perform and help severe/possible anaphylaxis management when the school nurse is unavailable or not in attendance. Delegate may not administer antihistamine (Benadryl).

Delegates will administer the auto-injector of epinephrine only in an emergency, and manage the care of students with severe allergic reactions

Regarding students who have been trained by their physician to SELF-ADMINISTER:

Delegates may need to assist students who are permitted to carry and self-administer epinephrine before, during, or after the administration of epinephrine. These students may carry one unit dose of an antihistamine to self-administer.

The law protects the district, the school nurse, and the delegate from liability.

Please note: In the event that an auto-injector is administered, 9-1-1 will be called to transport the student to the nearest hospital. A delegate from our school will accompany the student if the parent is not present.

PARENT MUST REVIEW AND SIGN PERMISSION FOR STAFF MEMBERS OF THE ROCKAWAY TOWNSHIP BOARD OF EDUCATION TO BE DELEGATES AT ANY TIME FOR ANY SCHOOL SPONSORED ACTIVITY.

By signing the Acknowledgment, I understand that the district, its employees or agents shall incur no liability, as a result of any injury arising from the administration of Epinephrine medication to the student. I hereby indemnify and hold harmless the district and its offices, employees and agents against any claims arising out of the administration of Epinephrine.

I understand that under New Jersey state law, a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

_____

_____ _____

Print Name Date

_____

Signature of Parent/Guardian

ROCKAWAY TOWNSHIP PUBLIC SCHOOLS

Physician Certification for **Self-Medication** Pursuant to N.J.S.A. 18A:40-12.3

Name of Student: _____ School: _____
Teacher_____ Grade: _____

Name and Address of Parents/Guardians:

_____
_____
_____
Medical Condition: _____
Medication/Dosage: _____
Possible Side Effects: _____

I certify that _____suffers from _____, a
(student) (condition)

Potentially life-threatening illness. I have discussed the administration of this medication with the above-named student and I certify that he/she is capable of and has been instructed in the proper method of self-administration of the medication in an emergency situation as directed above.

_____ _____
Physician's Signature Date

_____
Physician's Name (please print)

Parent Acknowledgment and Authorization Pursuant to N.J.S.A. 18A:40-12.3

I hereby authorize the above-named student to self-administer medication in potentially life threatening situations as evidenced by my submission of the above Physician Certification.

By also signing the Acknowledgment, I understand that the Board of Education, its employees or agents shall incur no liability, as a result of any injury arising from the self-administration or medication of the student. I hereby indemnify and hold harmless the Board and its offices, employees and agents against any claims arising out of the self-administration of medication by the student.

_____ _____
Parent or Guardian Signature Date

_____ _____
Parent/s or Guardian's Name (please print) Student's Name (please print)

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